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	155772	A. BUILDING 01 B. WING	06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COBBLESTONE CROSSINGS HEALTH CAMPUS	1850 E HOWARD WAYNE DRIVE TERRE HAUTE, IN47802

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/15/11 Facility Number: 011906 Provider Number: 155772 AIM Number: 200912380 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Cobblestone Crossing Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This fully sprinklered facility was	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	located on the north side of a one story building determined to be of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms. The facility has a capacity of 60 and had a census of 43 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/21/11. The facility was found not in compliance with the aforementioned requirements as evidenced by:			
K0048 SS=F	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review and interview, the facility failed to ensure the facility fire plan included all elements required for the protection of 43 of 43 residents. This deficient practice could affect all occupants. Findings include:	K0048	No residents to date were affected by this exclusion in the policy.The policy was updated to include removing a resident to another Smoke compartment in the event of a fire.Staff will be inserviced on the new policy change by 7/14/11.Maintenance Director or Executive Director will observe during monthly fire drills to assure policy is followed.All fire drills will be reviewed in Quality	07/14/2011

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	Based on review of the facility fire safety procedures titled When the Fire Alarm Sounds with the maintenance director and administrator on 06/15/11 at 3:25 p.m., the plan referred to removal of a person in danger but made no reference to evacuation from the smoke compartment. The administrator said at the the time of record review, residents would be moved behind fire doors but agreed the issue of where anyone might evacuate to was not addressed in the policy. 3.1-19(b)		Assurance Committee on a monthly basis to assure proper procedures are followed.	
K0062 SS=F	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5			
	1. Based on record review and interview, the facility failed to ensure 1 of 1 fire hydrants providing water to supplement the automatic sprinkler system was tested annually. NFPA 25, 4-3.2	K0062	No residents were effected by this deficient practice.Fire Hydrant will be flushed by local fire department.Documentation from Fire Department will be reviewed by E.D. annually.All annual documentation will be reviewed by Quality Assurance commiee	07/14/2011

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	requires hydrants shall be tested annually to ensure proper functioning. Each hydrant shall be opened fully and water flowed until all foreign material has cleared. Flow shall be maintained for not less than one minute. This deficient practice affects all occupants. Findings include: Based on interview with the maintenance director on 06/15/11 at 1:10 p.m., the facility owned one fire hydrant on the property. A review of Sprinkler Inspection Reports for the past year was conducted with the maintenance director on 06/15/11 at 2:40 p.m. No record was found for the flushing of the hydrant. The maintenance director said at the time of record review, the flush has not been done. 2. Based on observation and interview, the facility failed to ensure 2 of 6 sprinkler heads in the laundry were free of foreign materials, such as grime and dust. NFPA 25, 2-2.11 requires sprinklers to be free of foreign		for compliance.	

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	materials. This deficient practice affects staff, residents and visitors in laundry where no residents were located. Findings include: Based on observation with the maintenance director on 06/16/11 at 1:10 p.m., two sprinkler heads in the laundry washer/dryer area were covered with a fuzzy gray lint. The maintenance director said at the time of observation, he had not been aware they were dirty. 3.1-19(b)			

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K0066 SS=E	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 18.7.4 Based on observation, record review and interview; the facility failed to enforce the smoking policy for the protection of residents in 1 of 4 smoke compartments. This deficient practice affects staff, visitors and 10 residents observed in the sun room. Findings include: Based on observation with the maintenance director on 06/15/11 at 1:00 p.m., a six inch flower pot	K0066	No residents were effected negatively for the deficient practice.All staff will be inserviced on our no smoking polcy.Maintenance supervisor will inspect all areas outside of building on a daily basis to search for evidence of smoking.Any issues will reviewed by QA Assurance Committee on a Monthly basis for further recommendations or monitoring.	07/14/2011

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	half full of soil was covered with a collection of cigarette butts outside the emergency exit from the sun room. The maintenance director said at the time of observation, this was a nonsmoking health campus and this area was not approved for smoking by anyone. He said one resident was "grandfathered in" for smoking privileges because he had been admitted prior to the no smoking restriction for the health facility and grounds. He said staff were sneaking out there to smoke on the overnight shift and had not been "caught." The administrator confirmed the statement on 06/15/11 at 3:20 p.m. A review of the company Employee Handbook smoking policy dated 2007 noted, "Smoking may be permitted in designated areas." Additionally, the same policy states, "No smoking shall be permitted in the areas directly or indirectly adjacent to entrances or exits for the general public." The maintenance director and administrator agreed at the time of record review, the exit from a a communal meeting place like the sun room was available to the			

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	general public. 3.1-19(b)			
K0076 SS=E	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4 Based on observation and interview, the facility failed to ensure a resident room in 1 of 1 smoke compartments used to store oxygen was separated by construction with a one hour fire resistance rating. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.2. NFPA 99, 4-3.1.1.2(a) requires at least one hour fire resistant enclosures shall be provided for the storage of oxidizing agents such as oxygen. This deficient practice affects staff, visitors and 14 residents in the 100 hall smoke compartment. Findings include:	K0076	No residents were negatively effected by the deficient practice.Staff will be inserviced regarding proper storage of Oxygen Canisters and not leaving extra canisters in resident rooms. Storage of oxygen will be maintained in the proper location that meets the requirements.All resident rooms where oxygen is utilized will be inspected daily for 30 days then weekly thereafter for 3 months.Results of reviews will be reported to Quality Assurance Committee monthly for further recommendations.	07/14/2011

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	Based on observation with the maintenance director on 06/15/11 at 12:05 p.m., four liquid oxygen containers (181 L capacity) were observed in carpeted resident room 112. A resident in the room had two tanks at her bedside with oxygen administered per nasal cannula. Two other liquid oxygen tanks stood against the doorway wall. The tanks were not in use. The maintenance director said at the time of observation he didn't know why there were so many tanks in the resident's room. LPN # 1 was asked at the time about the oxygen containers in the room. She said the resident required oxygen at 12 L/min which was a higher than the normal flow rate for most residents. The need for oxygen required frequent replacement of the oxygen tanks and two extra tanks were kept in the room because the oxygen storage supply room could not accommodate all the oxygen tanks required for residents in the facility. This was confirmed at 12:10 p.m. The oxygen supply storage room was filled to capacity			

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	with 12 liquid oxygen tanks, one e-cylinder oxygen tank and a large helium cylinder. The maintenance director said at the time of observation, he had been unaware of the storage overflow problem. He agreed the resident room, which was carpeted, had no ventilation to the outside, and no self closer on the door which was rated for 20 minutes was not designed for liquid oxygen storage. 3.1-19(b)			
K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 2 oxygen transfer	K0143	No residents were negatively affected by this deficient practice.A sign will be posted outside the Oxygen Transfer	07/14/2011

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	sites was posted with a sign indicating oxygen transferring was taking place. This deficient practice affects staff, visitors and 14 residents on the 100 hall. Findings include: Based on observation with the maintenance director on 06/15/11 at 12:15 p.m., a liquid oxygen supply storage room was located on the 100 hall. The maintenance director also identified it at the time of observation as the site for transfilling portable oxygen tanks. There was no sign posted indicating oxygen transferring was occurring in the location. 3.1-19(b)		room to indicate when oxygen is being transfered.Staff will be inserviced on usage of the sign and when to utilize.Placement of sign will be monitored by Administrator on a daily basis for 30 days.Results of monitoring will be reported to the Quality Assurance committee on a monthly basis for further recommendations.	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency	K0144	No resident were negetively effected by this deficient practice.Maintenance Director will run the generator under load for the reguired time and document the time before generator turns on. The Administrator will review the log weekly to assure compliance. The generator logs	07/14/2011

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	lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation of generator equipment on 06/16/11 at 1:25 p.m. with the maintenance director, an emergency stop for the generator was located on the generator itself. The maintenance director said at the time of observation, there was no		will be reviewed by the Quality Assurance Committee on a monthly basis to assure compliance.The remote manual stop has be intalled.	

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	remotely located emergency generator shut off device for generator which was installed in 2008. The maintenance director said he had contacted the generator contractor for the installation, but had no set date scheduled. He called the generator contractor who said he planned to do the work sometime "next week." 3.1-(19) b 2. Based on interview and record review, the facility failed to provide complete documentation of 1 of 1 emergency generator's testing. LSC 7.9.2.3 and NFPA 99, the Standard for Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions and at a capacity not less than 50 percent of the total EPSS (Emergency Power Supply System load or not less than 30 percent of the EPS			

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	(Emergency Power Supply) nameplate rating, whichever load is greater, at least monthly, for a minimum of 30 minutes. NFPA 99, 3-4.4.1.3 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than seven days. NFPA 99, 3-6.3.1.2 requires the emergency system to be arranged so, in the event of failure of the normal power source, the alternate source of power will automatically connect to the load within 10 seconds. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all occupants. Findings include: Based on review of the Generator Log Sheet with the maintenance director on 06/15/11 at 2:50 p.m., documentation for emergency generator load tests were documented based on trip			

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	meter readings. The maintenance director said at the time of record review, the generator tested automatically under load each week. The start and stop times and load transfer times were not documented. The maintenance director said the generator started within "a few seconds." 3.1-19(b)			